Primary Care Network
Substance Misuse Management in General Practice (SMMGP)

November 2001 **Newsletter No.21**

Primary Care Specialist Providers - The Future of the NHS?

The Drug Misuse Clinical Guidelines defined three levels of practitioners – the specialist, the specialised-generalist and the generalist. These definitions were based on the service delivery and employment models of that time, which even though was only two and a half years ago are now becoming increasingly redundant. New flexibility's, including the formation of Primary Care Trusts with their ability to employ staff, the new flexibility of Personal Medical Services and the increasing diversity of skills and tasks undertaken directly in primary care means that we need to re-examine the role that general practitioners can have in the future National Health Service.

Given the increasing prevalence of drug misuse and the new flexibilities in service provision, it is perhaps no longer appropriate or ideal to concentrate all expertise in specialist addiction centres or indeed within the psychiatric services. Local populations require ready access to addiction services integrated with all the local health and other provision.

Should specialist services now be considered to include addiction psychiatrists at one end of a spectrum and primary care specialist providers and consultant psychiatrists with 'special responsibility' for substance misuse at the other end? Certainly, general practitioners have been filling the gap in specialist provision for a number of years and in some cases are running drug and/or alcohol services to a great level of sophistication.

This paper does not undermine the need for specialist addiction services, rather that they should be enhanced by the development of specialists from primary care. After all specialist addiction psychiatrists are a rare commodity, with only about 50 in the United Kingdom, and their expertise and leadership not in doubt. However, perhaps the time is ripe to consider that general practitioners can, and do perform at least as well, bringing with them their unique and in-depth knowledge of primary care to provide effective shared care and community based services [Delivering perhaps a more rounded package of health care which addresses broader aspects of people's lives than a traditional addiction focus - Ed.].

What is now needed is a drive to define and accredit practitioners at the intermediate and specialist levels, especially for those practitioners who do not come through the traditional psychiatric training route.

General Practitioners with Special Interest GPwSI - The Royal College of General Practitioners is perhaps taking the lead in defining new roles and career pathways for GPs, with the introduction of the concept 'General Practitioner with Special Interest'. This can broadly be thought of as congruent with the specialised - generalist, or the intermediate practitioner as defined within the NHS Plan. Though the term is new the concept is not. Many general practitioners have been acting in this capacity for a number of years, largely unrecognised except within their local area. It is apparent that a spectrum of activity and level of services has been provided. At one end is the large number of general practitioners who informally are regarded as the 'expert' within their own practice or their immediate locality. These doctors see and treat patients presenting to their practice and perhaps offer advice to other local general practitioners. They also are likely to take part in training programmes. The next level of provider would be the practitioner who provides care through a hospital or specialist provider, perhaps having a sessional payment and being part of a wider drug team. They will in the main undertake some specialist prescribing and undertake the care of patients with complex needs. Within their own practice they may also take the lead role for drug using patients and due their increasing competence perhaps undertake the care of a number of patients in their surgeries that would normally be considered to fall into the specialists domain. The new Royal College of General Practitioners Certificate in Drug Misuse will provide a some level of uniformity in regards to the 'accreditation' of these intermediate practitioners [As yet this is only available in England. There are discussions to introduce this in Wales, Scotland and Northern Ireland, Ed.].

Specialist general practitioners as medical lead for drug services - The end of the spectrum of general practitioners involved with substance misusers are the smaller number who have been providing services at a specialist level, at least to the level that would be provided by consultant psychiatrists with 'an interest' in substance misuse. Some of these doctors will be managing drug teams, such as community liaison services or traditional based community ***(Continued p.2)***

(Continued from p.1) drug teams, for example in Sheffield, Glasgow, Brent and Lambeth and Southwark. Others are employed and paid to provide a sector wide service to drug users – as an adjunct to the specialist services or in some cases instead of. Other general practitioners at this level have been providing treatment that would normally be considered to be at a specialist level, such as injectable prescriptions. Examples exist of whole practices, usually through personal medical services arrangements, dedicated to the treatment of drug users and their families alone. In all of these examples, doctors have perhaps been accepting referrals from other practitioner's within the locality and may have devised local arrangements to facilitate this. With all of these levels of activity comes an array of payment schemes, ranging from no additional remuneration to a complex contract with defined items of service payments and conditions. In some areas, the lack of addiction specialists has meant that increasingly health authorities and now Primary Care Trusts are turning to general practitioners to fill the gap rather than appoint perhaps a consultant psychiatrist with no specific training in the addictions.

These practitioners, would still in the main be generalists, working with non drug misusing patients and providing care in a primary care setting, though for a significant majority of their working day or week act as a specialist practitioner.

These general practitioners on the whole have learnt and developed their skills and knowledge through working with drug users and through attending courses and conferences. In the main they currently include leaders in the primary care drug misuse field, with amongst them drivers of initiatives such as the Management of Drug Users in General Practice Conference, the Primary Care Network for Substance Misuse, the Pan London Primary Care Network for Substance Misuse, The Substance Misuse Management in General Practice Newsletter, Shared Care Workers Forums in the north and south of the country, the Pharmacy Misuse Advisory Group/PharmMag and more recently the RCGP Certificate in Drug Misuse.

The way forward – core competencies, roles and responsibilities. The way forward is to define the core competencies, roles and responsibilities of all these groups of practitioners and then to define the clinical governance, support and contractual arrangements associated with them. The core activities should reflect the Clinical (e.g. prescribing, relapse prevention), Consultancy (e.g. shared care working) and Commissioning (local service development) roles inherent in this position.

Discussion paper by Dr Claire Gerada - Chair of the RCGP Expert Advisory Group – Responses to this article can be sent to cgerada@rcgp.org.uk or c.gerada@btinternet.com

Example Job Description/Discussion Paper GP with Special Interest (GPwSI)

Somewhere Primary Care Trust

Post:	GPwSI/Specialised Generalist General Practitioner – Salaried GP in Drug Misuse
Salary:	£45,000 - £60, 000 per annum equivalent (pro rata)
Hours:	3 sessions per week
Base:	Somewhere Community Drug Team (SCDT)
Working Relationships:	Somewhere Intermediate Care & GP Liaison Teams
Managerial Accountability:	Somewhere PCT Manager
Clinical Accountability:	Clinical Director of Community Drug Service/ PCT Clinical Governance Lead

Responsibilities:

- **To participate in developing an Intermediate Care Service in drug misuse to patients registered with the 27 practices of Somewhere PCT. To provide skilled assessment, treatment and care to patients with drug problems within agreed up-to-date working protocols developed by the SCDT.**
- **To work closely with the Intermediate Care Nurse and Criminal Justice Worker, develop good communications with GP liaison teams and to contribute to multidisciplinary care planning and team meetings. Clinical support and advice will be available from the Clinical Director and other SCDT professionals.**
- **To ensure that accurate notes of all patient consultations and treatments are recorded and appropriate communication is made with the referrer/practice, pharmacist and GP liaison team.**
- **To assist the Clinical Director in the formulation of philosophy, protocols and policies for the treatment and management of drug misuse in liaison with the SCDT teams, GPs within the Primary Care Trust and the Shared Care Monitoring Group.**
- **To contribute to the provision of support, education and training to primary care by the SCDT.**
- **To develop and maintain effective liaison with other agencies in the field of drugs and alcohol, including non-statutory services, specialist drug and alcohol services and social work teams, community mental health teams and hospital services.**
- **To develop a programme providing accessible services for blood borne viruses – including provision of Hepatitis B vaccination if required.**
- **To assist in service monitoring and evaluation of the Intermediate Care Project, taking part in clinical audit and research as required, and keeping up-to-date with developments in the drug misuse and related fields, in order to effect changes in clinical practice.**
- **To participate in own supervision; work with the manager and Clinical Director to set and review own objectives for training, personal and professional development.**
- **Other duties as agreed with the SCDT Manager**

Discussion paper **by Dr Claire Gerada - Chair of the RCGP Expert Advisory Group. Could people please send examples of contracts with either HA or PCTs for the care of drug users to cgerada@rcgp.org.uk or c.gerada@btinternet.com**

Shared Care Monitoring Groups Update

As previously reported, each Health Authority has been funded to set up a Shared Care Monitoring Group (SCMG) as originally recommended in the 1999 Clinical Guidelines. The groups are intended to oversee the development of high quality primary care based drug dependency services as well as having a role in monitoring and reducing drug-related deaths. Group membership requirements include GP and Local Medical Committee (LMC) representation. The majority of localities in England now have a SCMG. Prior to the funding to Health Authorities in December 2000 we were only aware of a handful of formalised SCMGs across the country. SMMGP advisers have attended many meetings held by the newly formed groups and we thought it useful to report on how they are progressing.

SCMG boundaries - SCMGs have set up in a variety of different ways, the most common being to split the group down into sub-groups corresponding to shared care scheme boundaries, and this usually means the boundaries of the local secondary care service. Focusing on a single scheme tends to be a natural and practical development for a group in its early stages. Sometimes an overarching group will remain and meet only occasionally. Exceptions to this are where for strategic reasons, groups form to cover larger areas e.g. A whole Drug Action Team (DAT) area or where six DAT areas are covered corresponding to a secondary service area.

SCMG membership -The chair is often a GP, Public Health doctor or Health Authority/Primary Care Trust (PCT) commissioning manager. The developing role of PCTs is likely to influence the type of chair corresponding to the increased strategic leadership by primary care. Membership largely reflects the Department of Health recommended stakeholders (Drug Action Team; Lead Drug and Alcohol commissioners; Local GPs; Local Medical Committee; Local training providers; Pharmacists; Primary Care Groups; Prison Health care workers; Public Health; Regional Drug Lead; Specialists & Non-statutory Providers). Lead GPs or Specialised Generalists are increasingly involved. In several cases the police are represented due to their involvement in treatment planning through DATs and drug related death issues. We have seen minimal representation by Regional Drug Leads or by Prison Healthcare Workers in prison areas.

LMC - LMC attendance has usually been obtained and in many cases has been useful in lending political weight to a scheme. Many LMCs have been constructive whilst representing the real concerns and reservations of some of their membership. In areas where GPs are not keen to enter into this work it has provided the opportunity for their representatives to explain what would need to be in place to secure GP confidence and formal LMC backing. This usually includes frameworks for clinical governance, training, accreditation, local protocols, role clarification, patient pathways and good GP support services. Some LMCs represent the conservative end of GP opinion. They may quite naturally be cautious of schemes which appear to expose GPs without adequate support or training, or which do not offer GP consultation or 'choice'.

Pharmacists - In the past in spite of their central role in the delivery of services and the regularity of their patient contact, pharmacist have often been left out of shared care planning, or at best consulted at a late stage. Pharmacist membership of SCMGs is now usual and this allows for the development of training and practice around drug awareness/attitudes, client group concerns, dispensing issues, in particular supervised dispensing, professional development and payment issues, premise development and security issues, shared care co-ordination, and GP liaison/ confidentiality issues.

SCMG issues and focus -The focus of each group has varied depending on the stage of development of shared care locally. Where there has been little or no formal shared care the focus is often on agreeing a basic model of delivery to proceed with. Where partners have not previously worked together, issues to do with models of service delivery often hinge on **fundamental differences in treatment philosophy**. For example a shared care scheme may be difficult to deliver if one partner is comfortable with longer term prescribing, maintenance and a liberal harm minimisation approach, with another partner focused on assertive patient change management towards the goals of reduction and abstinence.

Another possible conflict could be **who or which agency manages or leads the scheme**. For example, are GPs the subordinate deliverers of treatment slots within a specialist led scheme? Are GPs equal partners with specialist services, both informing each other's practice and protocol development? Are GPs the clinical and service delivery leads heading up the local specialist agencies or indeed 'rival' agencies? Another example is where local pharmacists may be committed to all patients receiving supervised dispensing all of the time as part of their professional development and service philosophy. This may be in conflict with the current practices and philosophy of local prescribers, not least the Clinical Guidelines. **Interpretation of the Clinical Guidelines** in line with an existing treatment philosophy and organisational agenda is commonplace.

Where there is an established scheme, history of joint working or common treatment outlook, the focus is usually on assuring good practice and consolidation of arrangements. In many cases sub-groups have been set up to focus on priority issues e.g. Pharmacy training.

Some areas have decided to appoint to post(s) that have the remit of actioning the SCMG responsibilities and being accountable to the group. The remit of such posts may not be purely limited to a co-ordination role but can include a developmental lead, delivery of training or facilitation. Up to now these posts have been principally created in areas with widespread existing shared care. There have been precursors to this sort of role in several areas prior to the establishment of SCMGs (e.g. Edinburgh, Brent & Harrow. Greater Manchester).

Changing service landscape – The implementation of shared care usually involves changes for all partners. This can occur as threatening, particularly so in light of the changing role of PCTs and Mental Health Trusts and the re-examination of GP roles and historical commissioning practices. The SCMG serves as an arena to understand and trade-out beliefs and agendas in the process of new service delivery arrangements.

Generally it feels like the SCMGs are fulfilling one of their purposes, that of giving more primary care ownership to the process of service delivery and thus more legitimacy to local shared care schemes. There are exceptions where there may be no local political willingness, initiative, or appropriate leadership to take up shared care. However, the rapid evolution of SCMGs around the country mostly seems to have provided venues for frank and earnest discussions which, whilst sometimes heated, often serve as a useful process for agreeing a way forward in what is a rapidly changing service landscape.

Introducing the National Treatment Agency (NTA)

The Government's drug strategy, Tackling Drugs to Build a Better Britain, emphasises the importance of providing treatment to people with drug problems to help them overcome their personal difficulties, and reduce the level of health problems, crime and social exclusion that are associated with addiction. This approach is supported by a growing body of research evidence which shows that appropriately delivered treatment works.

The drug treatment sector in this country has developed in an ad hoc manner over the last 30 years, although this has fostered innovation it has led to wide variations in coverage, methodologies and quality. There is also a significant gap between the number of people requiring treatment and the number of places available, so many areas of the country have long waiting lists.

Faced with this situation, the government took two significant actions in the most recent spending review. First was the decision to pump new money into the system – an extra £270 million in the 3 years from April 2001 to March 2004. Secondly, the decision was made to create an independent body to oversee the spending of that money, and to lead a drive to improve the coverage and quality of treatment services. Consequently, the National Treatment Agency for Substance Misuse came into being as a Special Health Authority on 1st April 2001.

What is the NTA?

The NTA is designed to be a small body, working with government departments and local purchasers and providers of drug treatment services. It will cover England only – other arrangements are in place in Scotland, Wales and Northern Ireland. As a Special Health Authority it is managed independently, having its own Board of Directors, but reports to the government through the Secretary of State for Health. The Board is made up of the Chair, Senior Staff of the Agency, four Non-Executive Directors, and departmental representatives from the Home Office.

The staff of the NTA has been appointed through the summer of 2001. The Chief Executive is Paul Hayes, who comes to the Agency from a background in the Probation Service. In addition to a small central team, based in London, there are 8 regional posts attached to each of the Government Offices for the Regions. Most of these have now been appointed.

Purchasing of drug treatment services will continue to be primarily implemented at a local level. Drug Action Teams (150 covering the country) have been asked to establish Joint Commissioning Groups to ensure that local treatment services are of optimum coverage and quality. Each DAT will appoint a Joint Commissioning Manager, and the NTA will work closely with these individuals and other DAT members to improve standards.

What will the NTA mean for primary care?

The NTA will be issuing guidance and promulgating standards around a range of drug treatment services. These standards will need to be taken into account when local commissioners are setting their contracts or Service Level Agreements. For example, if a GP is working at the GP with Special Interest (GPwSI) /Specialised Generalist level they are likely to be required to have access to services which could include:

- **Dose assessment services**
- **Specialist prescribing services (this may be available on a District wide level)**
- **Services able to provide care to young drug users**
- **Personal supervision**
- **Specialist advice**
- **In patient services**
- **Needle exchange**
- **Supervised ingestion services**
- **Psychological services, including relapse prevention**
- **Shared care provision**
- **Direct access services**

At practitioner level, the level of service provision depends in part on how the GP delivers the intermediate care. However, the NTA will play a role in supporting the implementation of clinical governance, accountability and monitoring arrangements that are in line across agencies. These will broadly comply with competency and practice frameworks laid out in the Clinical Guidelines.

At an organisational level primary care is well represented within the NTA with Dr Berrry Beaumont as the GP Non Executive Board Member and Don Lavoie as Commissioning Manager. Both are Advisory Group Members for SMMGP. There are three expert advisory groups to help keep the NTA informed. The group on substitute prescribing also has good representation from primary care.

Key areas of activity

As the extra money for drug treatment is being invested now it is important that the agency becomes active quickly. Following is an explanation of some of the key areas of activity that will be pursued in the first year.

Treatment planning - Each of the 150 Drug Action Teams in England has been asked to align the spending of all its members behind a jointly agreed treatment plan. The first versions of these were produced in February 2001, relating to plans for the financial year 2001/2002. In October 2001, the NTA will produce a template and guidance for the second year's treatment planning process which will include figures on the size and distribution of the pooled budget 2002/2003.

Performance management - The NTA will need to assure itself that DATs are using the pooled treatment budget effectively and that adequate services are being provided. To this end structures will be established to manage the performance of DATs and to track their expenditure on drug treatment. NTA Regional Managers will work closely with the Home Office's Drug Prevention Advisory Service to help DATs drive up standards locally but will also hold DATs to account for poor performance.

Human resources- There is a significant shortage of professionals available to work in this sector, and no clear framework for training and professional development. The NTA will address this key challenge by leading a national recruitment drive, to be linked with volunteering and apprenticeship schemes amongst employers in the field. The Human Resource Strategy will also include work on developing a clear set of competency standards for the main roles within the sector, and widely available training courses relevant to a range of skill types and levels. Commitment to staff development will be a key component of a strategy to retain staff which will complement additional recruitment. The NTA will also work with other professional bodies to ensure that substance misuse issues are adequately covered in the training of related professionals such as doctors, nurses, social workers and probation officers.

(***Continued on page 5)***

(Continued from p.4 – Introducing the NTA)

Quality assurance - Specialist drug treatment services in this country vary widely in quality. Some work on defining quality standards has begun (notably the QUADS project), which the NTA will use as a basis to develop a set of clear standards and benchmarks for all modalities of drug treatment. Commissioners will increasingly be expected to show that the services they purchase comply with these standards.

Assessment and care management - The process of assessing the problems of a drug misuser, and putting in place appropriate services is complex, involving many different agencies. In order to achieve the best possible outcomes, and the most efficient use of resources, each DAT will need to develop an integrated approach to assessment and case management. Guidance on the most effective models of care should be available for consultation in the autumn. The NTA will be piloting a range of approaches and systems with a small number of DATs to optimise the effective implementation of high quality intervention. As the learning from these pilots emerges guidance will be issued to DATs on how best to develop integrated systems, with all DATs expected to move towards such an approach during 2002.

Research - The evidence that substance misuse treatment is effective in moving users away from crime, and improving their health and social functioning is significant and growing. However to provide a fuller understanding of what forms of treatment are most effective for the range of users at different stages of their drug using careers a long term programme of research and monitoring is required. The NTA will work with other research funders to plan and purchase a range of projects designed to answer key questions facing the field.

User consultation - As we go through the process of expanding and improving the drug treatment sector, we need to ensure that the services we are purchasing are relevant to the needs of the group that we are targeting. One important way to inform this process is to create structures by which service users can contribute their views and expertise to the treatment planning process. The NTA will be encouraging every DAT to establish lines of communication with user groups, and will ensure that they are included in policy consultations at national level. The NTA has set up a national group to discuss how this should be done and has involved the Drug Users Development Agency and the Methadone Alliance.

Alcohol-The NTA was originally established to cover drug treatments only but strong arguments exist for combining this with a similar responsibility for the alcohol treatment sector. Many of the treatment approaches and provider organisations cover both sectors, but the strategic approach and funding streams for alcohol treatments are less well defined. The NTA will make early recommendations to Ministers on the best way forward.

The NTA exists to improve the quality and availability of treatment for drug misusers. To be effective the agency will need to engage the active collaboration of commissioners, drug service providers, generic services, drug misusers, and the wider community. The NTA is committed to being an open responsive organisation demonstrating transparent decision taking and a willingness to engage in dialogue and debate. We look forward to working with others to meet the challenge of making drug treatment in England a benchmark of quality.

How to contact the NTA: National Treatment Agency for Substance Misuse, 5TH floor, Hannibal House,
Elephant and Castle, London, SE1 6TE
Telephone: 020 7972 2214 Fax: 020 7972 2248
E-mail: nta.enquiries@nta.gsi.gov.uk

CONTACT SMMGP TO BE ON OUR MAILING LIST

SMMGP Recent Paper and Article Review

1. **'Outcomes after methadone maintenance and methadone reduction treatments: two-year follow-up results from the National Treatment Outcomes Research Study (NTORS)'** Gossop M,.et al., Drug and Alcohol Dependence: 2001, 62, p 255-264 and the previous **'Patterns of improvement after methadone treatment: 1 year follow-up results from (NTORS)'** Gossop M., et al Drug and Alcohol Dependence: 2000, 60, p275-286. These papers confirm that the benefits of out-patient methadone prescribing persist for at least 2 years. Amongst the patients reviewed there was a 2% reduction in the risk of regular heroin use for each extra mg of methadone received. Severely dependent users gained the most and those intended for reduction did less well the more times their doses were cut in the first year and had a worse retention rate. Low doses of methadone in the UK are a concern because higher doses have better retention rates and outcomes. Methadone programmes in the UK do achieve benefits, but there is substantial room for improvement. A fifth or more patients appear to be in the wrong treatment or need greater doses or greater support in order to improve. Assessment and treatment planning should be geared to meeting individual need rather than clinic policy (From Nugget 5.9 in ***Findings***) **Five-year NTORS follow-up report and bulletin available on www. *doh.gov.uk/drugs/research.htm***

2. Three feature articles in the magazine 'Druglink' issue 5, September/October 2001, about the different drug policies in Wales, Scotland and Northern Ireland - 'United Action'. Welsh strategies have attempted to address substance use in its fullest sense, including alcohol, with Drug and Alcohol Action Teams. In Scotland the Scottish Executive quickly established a range of initiatives to tackle its particular problems. In Northern Ireland an overview is given of the way drug problems are handled where all aspects of life have been influenced by the politics of violence.

"Working with Substance Misusers in Primary Care" A National Conference

Friday 7th December 2001 at the GMB National College, Manchester

Organised by The North West GP Liaison Workers Forum in association with Oldham Community Drug Team and SMMGP

This is a one-day conference aimed at all practitioners working with drug and alcohol users in primary care - GPs, pharmacists, and practitioners from primary care teams, drug workers and GP liaison workers. As the drugs field struggles to make sense of the huge changes affecting it (the growing significance of primary care, the potential impact of the National Treatment Agency, the standards expected of practitioners by the 'Orange Book' Clinical Guidelines, and so on), this is an opportunity to hear more about the policy and practice issues involved in supporting primary care, and explore some of the practical aspects of this work.

Cost: £75, including lunch and refreshments, and post-conference pack. **PGEA** accreditation applied for.

Booking forms available from Mark Birtwistle on 0161 905 1544, E-mail smmgp@lineone.net and Christine Connor on 0161 331 5094, E-mail Christine.Connor@exchange.tgcps-tr.nwest.nhs.uk

The Impact of Prohibition on Treatment – Does Our Policy Work?

I write this memorandum as a general practitioner who established and manages Torbay's Primary Care Addiction Service. For one day a week I treat specialist drug clients from the specialist service waiting list, and for the remainder of the week I work as a general practitioner, but I also look after drug clients within my surgery.

I was very pleased to learn that the Parliamentary Commission had been established to look at if the Government's Drugs policy is working. I feel strongly that this enquiry will succeed only if it can detach itself from some of the current preconceptions that surround the drug debate. There are two main issues which I would hope this committee would look at:

- **Whether a policy of criminalising drug misuse and drug prohibition is cost effective.**
- **The second major issue is that current debate seems to hinge upon an artificial distinction between hard and soft drugs, and "non-drugs" such as tobacco and alcohol.**

Cost effectiveness of drug prohibition - I had always assumed that the reason for criminalising drug misuse was to limit supply of the drug and therefore the harm that occurs. Certainly in Torbay there is an unlimited supply of illicit drugs, and drug misusers can obtain as much heroin as they require 24 hours a day. Our town centre is alive with a trade whereby young men gather in groups of 5 or 6 near phone boxes and then go off down a back alley to complete the deal. You cannot distinguish between dealer and drug misuser, and most drug misusers wheel and deal to afford the cost of their criminalised drug supply.

I am sure with the right remit that a statistician could prove that just as alcohol prohibition failed in the United States during the 1920's, drug prohibition has similarly not been successful. Politically, both nationally and internationally this may be a "bitter pill to swallow" and whatever the statistics, holes could be picked in the statistics. To move the debate on may need a large multi-centre trial to examine whether supplying drug misusers with pharmaceutical heroin (diamorphine) legally would be more cost effective than criminalising its use. Technically, if we were to establish a large multi-centre prospective cross-over trial using diamorphine first line as a substitute therapy for heroin, we could at the very least establish the cost to society of drug misusers obtaining illegal supplies of prohibited heroin and compare this in the cross-over part of the trial to providing legally prescribed diamorphine. I am not sure who would be interested in setting up such a trial; it may be of interest to the National Institute of Clinical Excellence, or the Department of Health directly, or it may be one of the academic units, and a teaching hospital could take this on.

Ultimately we need to establish whether the cost of criminalising drug misuse is money well spent by society, and whether decriminalising the misuse would be more cost effective. I am not sure whether the Audit Commission has that kind of experience and expertise to answer this question.

***Hard* v *soft* drugs** - At the present time we have a misleading system of describing different categories of drugs and non-drugs. We have soft and hard drugs, we have non-drugs, such as alcohol and tobacco, and we have different schedules of drugs based on their legal category. These categories of drugs have little scientific basis, but rather arise from society and culture. It is an accident of history that Sir Walter Raleigh came back from his travels with tobacco rather than opiate or marijuana, and through this accident tobacco has the status of a non-drug, whereas since 1915 opium has been criminalised. I feel that if we are to make progress in this area we need to establish new nomenclature which is independent of either history culture or society. One way of achieving this would be to look at all drugs whether they be soft, hard, alcohol or tobacco, and consider their safety profile. When we are making decisions as to which category to place drugs in, or whether to criminalise or decriminalise a drug we could then look at those decisions in the light of the safety implications that arise.

We also need to look at safety, not just in terms of street heroin which is available which is impure and the techniques of injecting which are dangerous, but if a pure form of heroin was available with sterile equipment, automatically the safety of this drug would improve, and it is often the criminalising of a drug that makes a drug contaminated and dangerous. Below I use a couple of examples in which we could develop a new safety profiling;

i) For heroin (diamorphine) short-term side effects include constipation, nausea and sedation. Heroin has no long-term side effects.
ii) In overdose heroin can be fatal because it stops one breathing.
iii) Health problems; these are mainly associated with an impure and criminalised supply and risky injecting practice, these include abscesses, hepatitis B and C, HIV.
iv) The safety rating of heroin under this system, because of the lack of long-term side effects and assuming a pure pharmaceutical supply, come out as being good to fair.

i) Comparing this with tobacco, the latter has few short-term side effects, however,
ii) It has long-term side effects including cancer, Ischaemic heart disease, arterial disease, stroke and respiratory disease which kills more than 100,000 per year in the United Kingdom, and incapacitates many others.
iii) Tobacco would, therefore, have a poor safety rating and clearly as a pharmaceutical product it would either not be licensed and be withdrawn.

I hope that I have illustrated that by accidents of history we have ended up in the perverted situation where non-drugs, such as tobacco which have horrendous long-term side effects, kill over 100,000 people a year. "Hard drugs", such as heroin, which has pariah status, have no long-term side effects, and most people are killed as a result of society's decision to criminalise it.

Conclusion - I do not have the answers to the current problems. However, I feel that unless we ask the right questions and tackle the problem with a new approach we will never be any further forward. In the meantime I will continue chipping away at the coalface and do what I can within the constraints of the current system.

Dr Stefano Cannizzaro - Article adapted from a letter by the author (19/09/01) to the Parliamentary Commission examining ***The Drugs Strategy: Is it Working***. Responses to author at stef.cannizzaro@gp-183118.nhs.uk, or South Devon Primary Care Addiction Service, Shrublands House, 8 Morgan Avenue, Torquay TQ5 5RSTEL: 01803 291129 FAX: 01803 215601

SMILE BOX
Read the alternative 'SMMGP' newsletter
Southern Missouri Meat Goat Producers (SMMGP) newsletter can be visited at www.meatgoatproducers.com/member_news.htm
Kidding you not! Ed.

Dr Fixit - Crack Cocaine

I recently saw a patient in surgery who claimed to be smoking £200 of crack cocaine daily. He said diazepam would help him stop. I didn't prescribe any, but could he have been right?

The first point to make is that daily use of £200 of crack cocaine is very much at the heavy end of crack use – both in terms of the amount used and the frequency of use. As such it is likely to involve a broad range of associated problems including physical and mental health, social/relationship problems, financial and /or legal problems. One can assume that such a level of drug use almost certainly means that for this individual crack cocaine occupies a considerable part of his day and/or night.

The patient requested diazepam claiming that it would help him stop. Before answering your question regarding the efficacy of diazepam it is just as important to consider how to respond in more general terms. When a patient presents with a problem for the first time, particularly such a "sensitive" problem the response of the GP is crucial:-

As with other patients if a condition has been identified that is likely to require a "treatment process" rather than a "one off treatment", the practitioner must respond in a manner that facilitates and encourages the engagement of the patient throughout the duration of that process, even if that process cannot start there and then. Consider the response to a newly diagnosed epileptic.

It is not always necessary or possible to initiate a treatment there and then – as often occurs with other patients there may be a need to gather more information, consult with others or monitor symptoms before making a final decision. Being honest and open with patients, informing them of the reasons for delay, encouraging them to come back and giving advice as to how to best manage the untreated condition will all help retain the patient in the treatment process. If the GP is aware of others who are more experienced or informed than an onward referral is the usual course of action – but still there is the issue of managing the problem and encouraging retention.

CONTACT SMMGP TO BE ON OUR MAILING LIST

To chose not to prescribe diazepam on this occasion was the correct decision – when else would a GP prescribe a course of treatment if , as the question implies, he or she does not know the efficacy or appropriateness of that treatment. The decision to prescribe or not constitutes only a part of this patient's care and is unlikely to be the most influential action regarding retention "in treatment" (perhaps unlike our experience of methadone patients). Research conducted by the Piper project in 1994 found that only 13% of a sample of 270 crack users had approached a "health service" for help with their crack use and only 1/3 of those who did so found the response the got to be of any use. Perhaps surprisingly this third were far more likely to have approached their GP than a specialist drug service and (reading between the lines) the service they appeared to value the most was one which showed respect, concern and a willingness to help, even if that help wasn't the one dictated by the "experts". In other words the way the service was delivered was at least as important as the service itself.

To answer your question: could diazepam have helped him stop? The treatment of crack cocaine users in the UK is very much in its infancy. Research from the USA suggests that of the many different pharmacological treatments tried most have little or no benefit for most of the users most of the time. That is not to say that there have not been some users who have responded well to such treatments but as a general rule success via this route is limited. Crack cocaine users often experience anxiety, paranoia and agitation in the hours and days after their last "hit". For most, these are akin to a "hangover" – what one could view as a normal and expected reaction following a period of crack use which will last from a few hours to a few days. Experience gained from the Piper Project suggests that the severity of these symptoms and their duration are dependent upon two key issues:

An understanding of why the user is feeling the way they are; and An understanding of what they and those around them can do to minimise both the severity and duration of symptoms and a belief that they have some control or influence over these factors.

Crack users often present reporting hopelessness and helplessness. When attempts to date to stop using have failed, it is common human response to take on the belief that we are powerless to initiate and sustain change. Crack users are no different from the rest of us in this respect. If we doubt our ability to make and sustain change in our lives we either look outside of ourselves for the solution or accept defeat. In most instances neither are recommended. One possible external solution for the crack user is prescribed medication, either because of a belief that it will actually help, or because if something has to fail then lets at least make it something other than me. It can be more acceptable form of failure.

In the UK and elsewhere anti depressants have been the favoured pharmacological treatment with support for both SSRIs and Tricyclics. What is not always clear in these cases is whether or not the anti-depressants is treating the "consequences of crack use" or a more general pre-existing depression which manifests itself when crack use stops. Either way anti-depressants remain a treatment option if low mood persists beyond two weeks after last use.

Benzodiazepines have also been prescribed to crack users – one could argue that they may perform a dual function: not only do they alleviate some of the "withdrawal symptoms" but by reducing this anxiety and agitation they play and important role in relapse prevention – effectively eliminating two triggers for future use (not dissimilar to the rationale behind methadone prescribing). Whatever the benefit felt by the patient, prescribing needs to be very short term (max 2 weeks?) and patients must be made aware that benzodiazepines are only a means to an end rather than an end in itself – other treatments/changes will also need to occur.

For many GPs (and many drug workers) crack users represent a threat: an unfamiliar condition, a person the media has taught us to fear – not a welcome combination. Yet if we take the time to get to know that crack user, we often find their problems are not so unfamiliar and that they are willing and eager to change. Prescribing is undoubtedly one of the many tools we can use to facilitate that change but it must be seen just as that: a tool of the trade rather than the finished product.

Answer: Tim Bottomley, Manager of PIPER (Peer Intervention Project for Education and Research)

Ed note: Management of crack users is an example where it is probably unwise to work alone. Make sure you know the resources locally - there are increasing numbers of voluntary sector projects set up to help people with this problem. Unfortunately there are very few that manage poly drug users, an increasing problem UK wide. Contact the PIPER Project (0161 8653322) or Blenheim Project (020 8960 5599) for useful booklets or advice for users and professionals

CORRECTION - Last issue Dr Fixit on lofexidine (Britlofex) reduction programme - We stated that - lofexidine is a ganglion blocker acting at the level of the spinal cord, also that opiate withdrawal is caused mainly by the release of large amounts of adrenaline into the blood stream when opiates are abruptly stopped. Reader feedback has informed us that lofexidine is an imidazoline derivative which binds centrally to the alpha $_2$ adrenoceptors. During chronic exposure to exogenous opioids, up-regulation of the neurons in the locus coeruleus region of the brain occurs. Sudden withdrawal of the opioid results in an increase in firing rate of the neurons and elevation of the amount of noradrenaline released lofexidine binds presynaptically to the alpha2 adrenergic receptors which decreases cell firing rate and suppresses the amount of noradrenaline produced, thereby dampening down the withdrawal syndrome. Hope that's more clear. Ed.

NEW SMMGP ONLINE DISCUSSION FORUMS
available on www.smmgp.demon.co.uk

1. Dr Fixit's Open Discussion Forums (www.smmgp.demon.co.uk)

i.SMMGP Issues & Misc - SMMGP related news and updates, suggestions, comments, etc
ii.Clinical Issues- Relating to the development of drug dependence in primary care
iii.Service Development - Relating to the development of drug treatment services in primary care
iv. Shared Care Monitoring Groups - For issues specifically relating to SCMGs
v.Resources & Events – Notification of useful web sites, articles, papers, books, conferences, etc

2. Dr Fixit's Online Surgery (www.smmgp.demon.co.uk)
This forum allows registered users to post questions which will be answered by Dr Fixit's expert team.

3. RCGP Course Forums (www.smmgp.demon.co.uk)
These forums/discussion area are available only to registered users who are working towards the Royal College of General Practitioner's Certificate in the Management of Drug Misuse

RCGP Certificate Materials Online
RCGP Certificate in the Management of Drug Misuse **materials are beginning to be available online at:**
www.smmgp.demon.co.uk.
These include the ***RCGP Learning Portfolio***, **The *RCGP Certificate Handbook***

New Project Contact Information – SMMGP is no longer at SMAS – see below

SMMGP PRODUCTION GROUP: ***SMMGP*** is edited by Jean-Claude Barjolin, Chris Ford, and Jim Barnard. The newsletter is produced with editorial and steering group input from: Dr Berry Beaumont, Dr Claire Gerada, Dr Jenny Keen, Don Lavoie, Dr Nat Wright

New SMMGP Project Team
- **Mark Birtwistle** – SMMGP Project Administrator: smmgp@lineone.net Tel: 0161 905 1544/ Fax: 0161 912 1067
- **Jim Barnard** – SMMGP Adviser (Southern regions): smmgp@freeuk.com Tel: 0161 905 1544
- **Christina McArthur** - SMMGP Adviser (Northern regions): cdtraff@lineone.net Tel: 0161 912 3240
- **Simon Morton** – SMMGP Adviser (Midlands regions): smmgp@lineone.net Tel: 0161 912 3118
- **Jean-Claude Barjolin** – SMMGP Editor/Adviser: PCNet@smmgp.demon.co.uk Tel: 01756 709708

Mailing address: SMMGP, Trafford Substance Misuse Services, Chapel Road, Sale, Greater Manchester, M33 7FD

Contributions please! Join the mailing list. Please photocopy and circulate newsletter

SEE OUR NEW SMMGP ONLINE DISCUSSION FORUMS **www.smmgp.demon.co.uk**